Our goal is to provide you and your family with the finest dental care available. Our philosophy revolves around the finest quality of dental treatment. The reason, we believe your teeth should last a lifetime. Our comprehensive approach involves a complete dental evaluation, utilizing the latest techniques with your specific concerns in cosmetics, orthodontics, TMJ, restorative and preventative needs in mind.

HEAVENLY SMILES DENTAL

PATIENT INFORMATION:

FIRST NAME: _____ LAST NAME: _____PREFERRED NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOMEPHONE: (_____)_____CELLULAR: (_____)_____WORK PHONE: (_____)_____

BIRTH DATE: _____/_____/_____ SOCIAL SECURITY #: _____-_____-_____ SEX: **M** **F**

EMAIL ADDRESS: _____ (Level of communication = Level of Success)

Your Previous/Present Dentist Name and Phone#: _____ Last Visit: 6 Months 12Months I want to get better. YES

EMERGENCY CONTACT INFORMATION:

FIRST NAME: _____LAST NAME: _____

CONTACT PHONE: (_____) _____ RELATIONSHIPTO PATIENT: _____

***whom may we thank for referring you to our office?**

☐ *FLYER* ☐ INTERNET ☐ OTHER: _____

☐ Love the location Enter for in office GAME >>>>> **FRIEND OR FAMILY** (please print name): _____

RESPONSIBLE PARTY INFORMATION: (if patient is a minor)

FIRST NAME: _____ LAST NAME: _____ BIRTH DATE: _____/_____/_____

ADDRESS: _____ Relationship to patient: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOMEPHONE: _____CELLULAR: _____

PRIMARY INSURANCE INFORMATION: (Only if you carry a current valid card with you)

EMPLOYER: _____ HR PHONE # HANDLING YOUR INS. LIMITATIONS: _____

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY #: _____-_____-_____ MEMBER / ID #: _____

INSURANCE COMPANY: _____ INSURANCE CO. PHONE: (_____) _____

At the time of your visit with us today you MUST present your Ins.card, coverage booklet, and a completed and signed dental ins claim form that you have requested and received from your ins. as we have confirmed those necessary actions at the time appt. was requested.

I UNDERSTAND THAT MY INSURANCE IS NOT A GUARANTEE OF PAYMENT; PER MY SIGNED AND AGREED CONTRACT WITH THEM. I UNDERSTAND THAT PAYMENT FOR SERVICES ARE REQUESTED BY THIS BUSINESS AT THE DAY OF MY VISIT.

PATIENTS SIGNATURE: _____ **DATE:** _____

PARENT SIGNATURE (if minor): _____ **DATE:** _____

NOTIFYING THIS OFFICE OF ALL FUTURE CHANGES IN THE ABOVE INFORMATION IS MY RESPONSIBILITY.

WELCOME To Heavenly Smiles Dental

HEAVENLY SMILES DENTAL Patient Medical History

PATIENT NAME:_____**DATE:**_____

Are you under a physician's care now? ____Y ____N If yes, why? _____

Do you have any chief complaint or concerns? ____Y ____N If Yes, what? _____

In what relative time frame do you want your concern to be addressed? _____ **NOW!** _____ 1 Week _____ 1 Month _____1 Year

Are you happy with your smile? ____Y ____N If no, explain why:_____

Would you like to have your teeth whitened? ____Y ____N

Would you want to replace any old crowns that do not match your other teeth or have dark lines at the gum? ____Y ____N

Would you like to change your black or silver fillings to white ones? ____Y ____N

Would you like to replace any old or stained fillings that show when you smile? ____Y ____N

Do you have any gaps, or missing teeth you would like to replace to improve your smile and bite? ____Y ____N

Would you like to straighten your teeth or tooth, to correct any crowding, spacing or an uneven bite? ____Y ____N

Do you snore? ____Y ____N If yes, on what level? ____Minimal ____Moderate ____Severe

Do you have sleep apnea? ____Y ____N If yes, what level? ____Minimal ____Moderate ____Severe

Do you feel tired after waking up, or feel like taking naps during the day? ____**DEFINITELY!** ____Y ____N

WOMEN: Are you pregnant/ trying to get pregnant? _____Y_____N If yes, how many weeks? _____
Are you taking oral contraceptives? _____Y_____N Nursing? _____Y_____N

Are you allergic to any of the following:

___Aspirin___Penicillin___Codeine___Acrylic___Metal___Local Anesthetics___Other, please list:_____

Are you taking any medications, pills or drugs? ____Y ____N Please List: _____

Do you have, or have had any of the following:

____Change in Bite
____Clenching/Grinding
____Dizziness/Loss of Balance
____Earaches/Ringing in Ears
____Ear stuffiness/Loss of Hearing
____Headaches/Migraines
____Jaw Clicking/Popping
____Jaw Locking/Catching
____Jaw Pain/Tired Jaw Muscles
____Neck Pain
____Sinus Trouble

____AIDS/HIV Positive
____Alzheimer's Disease
____Anaphylaxis
____Anemia

____Angina
____Arthritis/Gout
____Artificial Joints/Heart Valves
____Asthma
____Blood Disease
____Blood Transfusion
____Bruise Easily
____Cancer
____Chemotherapy
____Chest Pains
____Congenital Heart Disease
____Cortisone Medicine
____Diabetes I or II
____Drug Addiction
____Emphysema
____Epilepsy/Seizures
____Excessive Bleeding
____Genital Herpes

____Glaucoma
____Hay Fever
____Heart Attack
____Heart Murmur*
____Heart Disease
____Hemophilia
____Hepatitis A/B or C
____Herpes
____High Blood Pressure
____Hives or Rash
____Hypoglycemia
____Irregular Heart Beat
____Kidney Problems
____Leukemia
____Liver Disease
____Low Blood Pressure
____Lung Disease
____Mitral Valve Prolapse*
____Prolonged Bleeding

____Psychiatric Care
____Radiation Treatment
____Recent Weight Loss
____Rheumatic Fever*
____Shingles
____Sickle Cell Disease
____Spinal Bifida
____Stomach Disease
____Stroke
____Thyroid Disease
____Tonsillitis
____Tuberculosis
____Tumors or Growths
____Ulcers
____Venereal Disease
____Yellow Jaundice
____Tobacco Use

Have you ever had any serious Illness not listed above? ____Y____N If yes, please explain: _____

_____